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EMPLOY-ABILITY

A Resource Guide

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Canadian Human Rights
Commission

Commission canadienne
des droits de la personne

Text:

J.B. McDonald.

Photos:

J.B. McDonald.

Health and Welfare Canada.

Design:

The G.S. Design Group Ottawa.

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EMPLOY-ABILITY

A Resource Guide



Canadian Human Rights Commission
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As an employer
you have an obligation
to find the best person
for each job.

The purpose of this booklet
is to help ensure that you don't overlook that person
simply because they have a physical handicap.

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Introduction

Most of us will become physically disabled at some time in our lives. This condition may be of such short duration that we do not experience the many frustrations of being denied jobs, accommodations or access to public facilities because we are disabled.

One out of every seven Canadians has a permanent physical handicap, either visible or invisible.

When you think about it, everyone has limitations, no one can do everything. With respect to employment, most people function best within a specific range of activities, but don't consider themselves handicapped because of it.

Sound business practices are based on a thorough analysis of all the important factors of a situation, rather than a quick evaluation of irrelevant or superficial ones.

It is unlikely that an employer would ask a candidate for an accounting position if they could ride a bicycle or swim a mile, since those questions have no value in predicting a person's success in a new job. All too often, judgements are made about the physically handicapped which are based on this sort of reasoning.

It is estimated that between 50% and 80% of all physically disabled people are unemployed, not for lack of motivation or marketable skills but because they are victims of society's stereotypes about them.

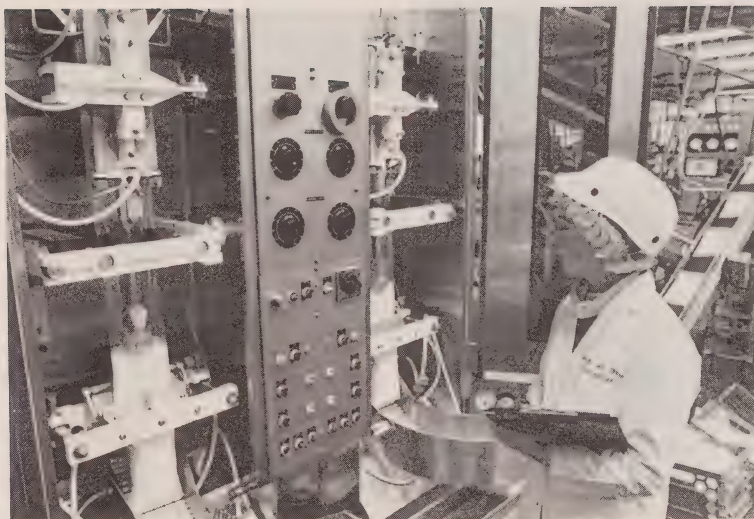
It has often been said that the attitudes of others are the greatest handicap to those with physical disabilities.

The word *handicapped* is used loosely to describe a great number of people who have a wide variety of physical limitations. The range of conditions and degrees of impairment are so diverse, that classifying a person simply as *handicapped*, makes no sense since many physical disabilities do not affect work performance. Each person seeking employment must be evaluated on their own merit.

As an employer, it is not necessary to know the medical background and reasons for various conditions. If you want to know whether a person can do a specific job, ask them, then give them the chance to prove it!

Many disabled people do not need special accommodations on the job and none want special treatment!

The terms handicapped and disabled are used interchangeably throughout this publication.





The Law

The Canadian Human Rights Act prohibits discrimination in employment on the basis of a physical handicap, except where there is a Bona Fide occupational requirement.

This Act applies to all federal government departments, agencies, crown corporations, businesses, industries and associations under federal jurisdiction.

The Canadian Human Rights Commission accepts complaints filed by individuals or groups of individuals, or the Commission may initiate complaints. Once a complaint is accepted, it will be investigated and a report will be made. Then if necessary, the Commission may appoint a “conciliator” who will attempt to reach a settlement. If all else fails the Commission has authority to establish a Tribunal to inquire into the complaint and make a decision.

A special program, sometimes called affirmative action, may be ordered to equalize opportunity for a group that has suffered from discrimination in the past.

Many of the provinces have similar anti-discrimination laws with respect to the physically disabled, and deal with complaints in a similar manner.

(See Appendix 1: Federal and Provincial Human Rights Commissions)



Misconceptions

The following section is concerned with dispelling some of the commonly held misconceptions about those with physical disabilities.

Myth: All legally blind people cannot see.

Fact: Only about 10% of those who are legally blind cannot see at all. The remainder have limited vision (20/200 or less, in the better eye with corrective lenses).

Myth: Blind people hear better than other people.

Fact: Impairment or absence of vision creates a greater dependence on the other senses. Those who are blind train themselves to listen more carefully. This skill can be acquired by sighted people with the same amount of practice.

Myth: All visually impaired people read braille.

Fact: Braille is read by only about 10% of the visually impaired population.

(See glossary: Visual Impairments)

Myth: All wheelchair users are paralyzed and confined to their chairs.

Fact: Many wheelchair users can walk with the aid of crutches, braces or canes but it is easier for them to use their wheelchairs.

Myth: Wheelchair users are sick.

Fact: People with varied disabilities use wheelchairs. Many have an isolated disability which is neither progressive nor does it cause any health problems.
Disabilities aren't contagious!

Myth: Wheelchair users cannot enjoy sex.

Fact: Wheelchair use stems from a variety of causes, many of which have no bearing on sexual functioning and none of which limit the persons' normal emotional needs.

(See glossary: Mobility Limitations)

Myth: Epileptics have seizures.

Fact: A small percentage of those who are epileptic have “grand mal” seizures. Others may only have “blank spells” for a few seconds, others may have short periods of non purposeful activity — chewing, staring, etc. Most of those taking the proper medication are seizure free.

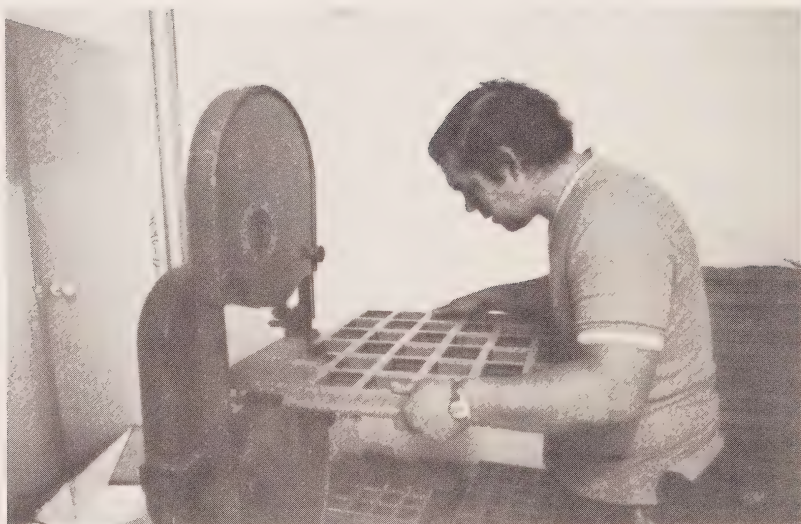
Myth: Epileptics are violent.

Fact: People who have epilepsy are no more violent or passive than the rest of society.

Myth: Epileptics have low intellectual capabilities.

Fact: People who have epilepsy, like all other people in society, exhibit the full range of intellectual potentials from low to high.

(See glossary: Epilepsy)



Myth: Deaf people can read lips.

Fact: Everyone reads lips to some extent in normal conversation. Even a practiced deaf listener can only understand 30%-40% of the spoken sounds. When communicating with a deaf person, face the person and speak in a normal tone of voice. A pencil and paper is useful if you feel you are not communicating clearly.

Myth: All deaf people lack the ability to speak.

Fact: Many deaf people speak, and have normal vocal abilities. Deaf people cannot automatically modulate their voices since they cannot hear themselves, so speech classes are necessary. Some deaf people are reluctant to speak in public because of the negative reactions they have received in the past.

Myth: Hearing aids correct hearing impairments.

Fact: Hearing aids do not correct a hearing deficit, they help improve hearing in some individuals.

(See glossary: Hearing Impairments)

Myth: All diabetics take insulin.

Fact: In mild cases of diabetes, a careful diet is all that is required to control the condition.

(See glossary: Diabetes Mellitus)

Myth: Arthritis affects only the elderly.

Fact: Certain types of arthritis can attack anyone at any time in their lives.

(See glossary: Arthritis)

Myth: Society has an obligation to take care of disabled people.

Fact: Society has an obligation to ensure that everyone is given a fair and equal opportunity to live their lives in dignity and is permitted to fully contribute their skills to the welfare of their community. The Federal Government and many provincial governments have accepted this responsibility for themselves as employers and extend this responsibility to those in private enterprise, through human rights legislations.



Tips on Helping Those with a Physical Disability

You may feel awkward about offering assistance to others who have physical disabilities. This is a common reaction for most people, since they don't know if they should help or how they can help. Keep the following things in mind:

- 1) Think first, is the person really in difficulty or are they simply doing something at their own speed and in their own way.
- 2) If you are uncertain, approach the person and quietly ask them if you can be of assistance. If they refuse, don't be offended, we all value our independence!
- 3) If a person needs help they will usually ask you. If you are uncertain of what to do, simply ask.

4) For safe handling of wheelchairs remember the following:

- Keep the wheelchair in control at all times.
- When passing through doorways go carefully since the rider's hand or foot may get hurt if you miscalculate the door width.
- Always let the person know what you are doing.
- Never leave a chair sitting without the brakes on.
- Don't go down a slope frontwards, the rubber handles on the chair may slip off.
- If the person's feet drag, tilt the chair back, especially if there is no feeling in the feet.

- When going up a curb, tilt the chair back, place the front wheels firmly on the upper level, then raise the back wheels.
- When going down a curb, pull the chair backwards, place the back wheels firmly on the lower surface then lower the front wheels.
- When going up or down a number of steps, it is safest to get a person to help. One in front and one in back.
- Before lifting someone from a chair, remove the arm rests if possible, then lift the person carefully without injuring your own back!

For many people, their wheelchair becomes part of their “personal space”, remember to keep your hands and feet off their chair unless you are helping in some way.

- 5) If you are present at the time when a person is having a grand mal epileptic seizure, you can help by following these simple procedures:
- Keep calm. You cannot stop a seizure once it has started.
 - Ease the person to the floor and loosen their clothing at the neck and waist.
 - Turn the person on their side so that the saliva may run freely from their mouth.
 - Do not insert anything into the person's mouth.
 - Do not give them anything to drink.
 - Do not restrict the person's movements except to protect their head.
 - After a short rest, most people can carry on as before.

6) When assisting a blind person remember the following:

- Inform the person of your approach and tell them when you are leaving.
- Use the person's name or lightly touch them to get their attention.
- When walking with a blind person offer your arm and indicate when approaching curbs and obstacles.
- To help a blind person into a car place their hand on the door.
- Seeing eye dogs are working animals, do not pet or distract them while they are guiding. Even if the dog is not working, ask the owner before approaching it.

7) When talking with a person who has a speech disability:

- Be patient.
- Speak normally, then pay attention to the answer given.
- The words may come out at a slower rate than you are used to, but this does not mean that the person cannot communicate intelligently.
- If you do not understand a phrase, simply ask the person to repeat it.



Affirmative Action

The Federal Government and many Provincial Governments include physical handicap as a prohibited ground of discrimination in their Human Rights Acts.

The best way to insure that discrimination of this type does not occur, is to actively recruit qualified people who are physically disabled. This procedure is sometimes called affirmative action.

An affirmative action recruiting program differs from regular recruiting methods. It is designed to provide opportunities for people who have been chronically disadvantaged by discriminatory job selection criteria which effectively exclude whole groups of people on the basis of perceived group characteristics, rather than individual qualifications. This sort of discrimination is referred to as institutional or systemic discrimination. People who are physically handicapped have to cope with attitudinal, physical and systemic barriers in their search for employment.

People who are deaf can do most jobs as well as those who can hear, but if a manager does not understand this, deaf people will not be considered for a position.

If a person with cerebral palsy is perceived to be sick rather than simply having a stable physical disability, there will be no employment opportunity.

If those with epilepsy are wrongly stereotyped as being violent they will be passed over as a bad risk.

If there is no proper access to a building, those in wheelchairs cannot even come to a job interview.

An enlightened manager who is willing to consider applications from people with physical handicaps, but unnecessarily asks for a minimum of five years experience again excludes those who have been unable to get that experience in the past.

It is for these kinds of reasons that an affirmative action program is necessary to redress the inequalities.

Only a comprehensive strategy for recruiting physically disabled people will insure that you get the best person for a given job.

The following elements should be part of the affirmative action program.

- A clearly stated policy on affirmative action should be drafted which includes objectives, timeframe and line responsibility for implementation.
- Senior management should consult with union representatives during the policy development stage to ensure their support.
- Senior managements' committment to the program should be communicated to all staff. Making one of these managers responsible for meeting the objectives is a good way to demonstrate that committment.
- Examine job classifications of presently available and future positions to ensure that the requirements are not arbitrary or excessive.
- A regular advertisement only in the daily newspaper may not reach that part of the community which you are aiming at. Notices of positions should be circulated in handicap association newsletters, through vocational rehabilitation offices, local radio programs etc.
- Ensure that application forms and interview criteria are free of systemic biases.

- Ensure that those brought in on the affirmative action program will have access to the same opportunities for training and promotion as other employees.
- Establish a clear set of performance objectives. This gives both the employee and employer a basis for evaluating the work done.
- Awareness sessions for all staff are important. If co-workers have negative attitudes or make incorrect assumptions about a person with a handicap, their work will probably suffer.
- After a set period of time evaluate the program and adjust it accordingly.

Remember that there are many people in the community working through various associations who are well qualified to assist you in recruiting and interviewing, advertising, job classification, vocational training, awareness training, accessibility and transportation. Very often these services are free. The resources are there, use them!



Employment Statistics

Insurance costs, safety and productivity are some of the many important issues to be considered when hiring a new employee. The results of two major studies on employment of the physically disabled provide some very interesting data.

The Dupont company which employs 1,452 disabled people, published the following results from their study:

Insurance: No increase in compensation and costs.

Adjustment to the Workplace: Minimal, it included some simple changes such as lowered work surfaces or addition of an entrance ramp, etc. Many employees required no special work arrangements.

Safety: 96% of the disabled employees had average or better safety records on and off the job.

Special Privileges: The disabled employees did not want to be singled out by receiving special privileges. Other employees did not resent the necessity of a parking spot near the plant entrance.

Acceptance: Each and every new employee was given an enthusiastic reception.

Job Performance: 91% of the disabled employees were rated average or better.

Attendance: 71% were rated average or better.

Length of Service: 93% were rated average or better.

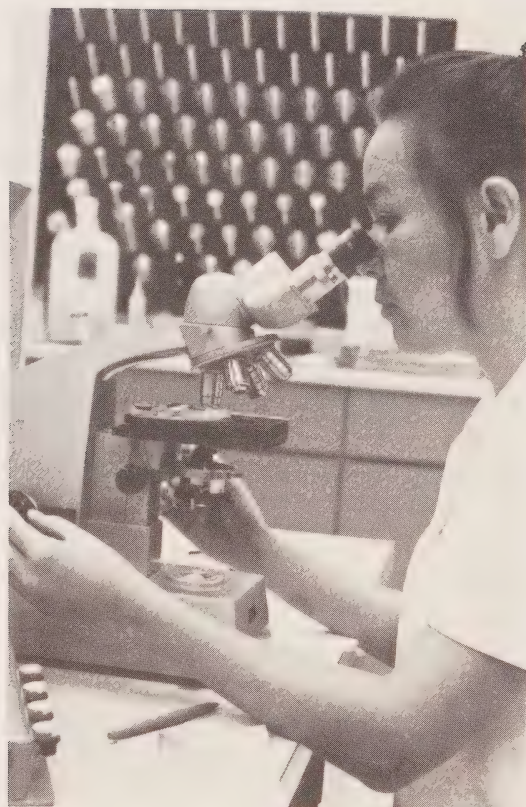
The Canadian Chamber of Commerce polled 3,000 corporate members who employed physically handicapped people. The results of their study were similar to Duponts':

Productivity: 88.4% were rated average or better

Attendance: 91.6% were rated average or better.

Length of Service: 93.8% had equal or better lengths of service

Quality of Work: 95% performed average or better.



Grants

There are both Federal and Provincial grants available to employers to aid in the initial employment of disabled workers.

The Canadian Employment and Immigration Commission provides grants covering from 40%-90% of the first year salary of a disabled person receiving on the job training. (Contact your Regional Office for detailed information)

Provincial Vocational Rehabilitation Departments have grants for certain types of vocational training, some assistance in upgrading accessibility of buildings etc. These programs vary in each province. (Contact your Provincial Office for detailed information)

Provincial Workers' Compensation Boards provide funds for upgrading accessibility and workplace modifications for those people receiving workers' compensation. (Contact your Provincial Office for detailed information)

Local Service Clubs provide funds for special community projects of this nature also.

(See Appendix 2: Federal and Provincial Offices)



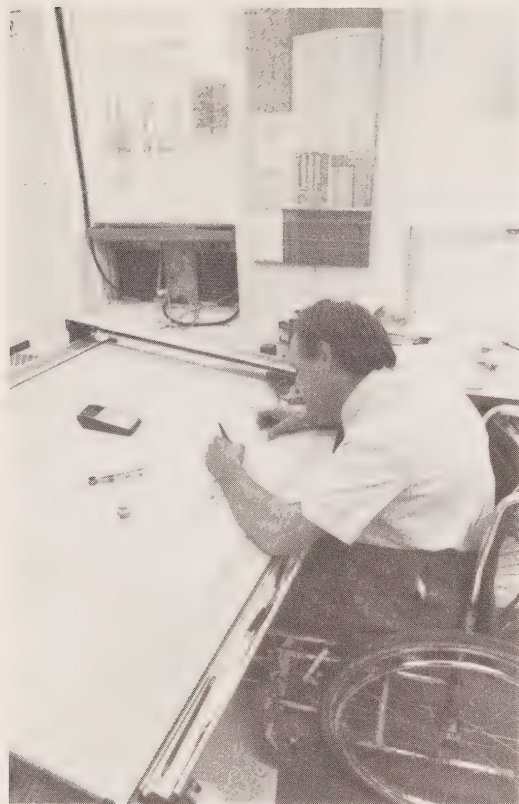
Technical Aids

Among the many technological aids available, there are talking calculators, machines which can actually read books to those who are blind, telephone devices to assist those with hearing impairments, wheelchairs which can climb stairs, and typewriters which can be controlled by the breath. Though special devices are not required by all disabled people, there are many aids on the market which are designed specifically for the workplace.

In some cases, this advanced technology is necessary, but in many more instances, an open mind and a bit of creative thinking is all that is needed to ensure that the handicapped employee is able to function fully and productively.

For more information on these devices, contact Canadian Rehabilitation Council for the Disabled.

(See Appendix 3)



Accessibility

The National Research Council of Canada has issued supplement No. 5 to the national building code called “Building Standards for the Handicapped 1977”. Provincial standards are similar to those in the national code which is cited here only for general guidance.

If accessible features are included in the original design of a building, the cost should not exceed 1/2 of 1% of the total.

Site Development

Almost any building can be made accessible to physically handicapped persons by planning the site, so that terraces, retaining walls and winding walks are used effectively. An accessible route should exist from the sidewalk or roadway and parking area to an accessible building entrance. This route should be located so that physically handicapped persons do not have to pass behind parked cars. Particular attention should be paid to the junction of walkways with driveways, parking areas and other walks. The provision of nonslip surfaces on steps, walks and floors greatly assist those with semi-ambulatory disabilities.

Wheelchair Dimensions

The dimensions of common models vary as follows:

	Range of Dimensions	Usual Dimension
Length	85.1 cm. to 121.9 cm.	106.7 cm.
Width when open	47.0 cm. to 76.2 cm.	66.0 cm.
Width when collapsed	22.9 cm. to 36.8 cm.	27.9 cm.
Height of seat above floor	35.6 cm. to 50.8 cm.	45.7 cm.
Height of armrest from floor	49.5 cm. to 85.1 cm.	74.9 cm.
Height of handle from floor	83.8 cm. to 135.9 cm.	94.0 cm.

Functioning of a Wheelchair

The average space for turning through 180° is 1.5 m by 1.5 m. A minimum width of 1.5 m is required for 2 wheelchairs to pass each other.

Functioning of an Adult in a Wheelchair

The upward reach from the floor ranges from 1.4 m to 2 m with an average reach being equal to 1.5 m. The average horizontal working reach at a bench or table is 45.7 cm beyond the front edge of the seat. The average forward reach upwards, for example, when using a wall mounted dial telephone is 1.2 m. Removable arm rests may increase some of these dimensions slightly. Transference from the chair to a car, bed or water closet is usually achieved either by a slide, after removing an arm rest, or off the front corner of the wheelchair. Ideally, the two seats should be level. In any event, the chair seat should not be more than 7.6 cm higher than the seat or bed.

Designing for Children

The preceding dimensions are for adults of average stature. In designing buildings for children, it may be necessary to alter some dimensions, such as the height of handrails.

Doors and Doorways

Doors that require little strength to operate, that have an easily gripped handle, that are reasonably wide and that do not have a threshold can be safely used by most people. Space for wheelchair manoeuvring should be provided on both sides of the door. Door handles should be of the lever type.

Ramps

A change in the level of a walk or floor area becomes a major problem for people with physical disabilities. Flat surfaces are desirable, but if a change in level occurs, a ramp of low slope should be used. As the slope of the ramp decreases, the number of people who can safely use the ramp increases; a slope of 1 in 12 is the suggested maximum. Provision of a nonslip surface at all times is essential. Where a ramp is located outside a building, it should be protected from snow and ice accumulation by providing a roof, snow melting device or other means.

Handrails

Handrails on only one side of a ramp are acceptable if slope is 1 in 12 or less, but it is preferable to have handrails on both sides regardless of the slope.

Buildings

As much of the building as possible should be accessible to physically handicapped persons, especially areas used by the public. Special attention should be given to the accessibility of entrances, washrooms and elevators. The international symbol of accessibility for handicapped persons was adopted in 1969 by the International Society for the Rehabilitation of the Disabled to indicate that building services are accessible to the physically handicapped. It is essential that the finish of all floors should have nonslip qualities even when standard flooring materials are used. Highly polished finishes should be avoided. Particular attention should be given to the selection of materials used on vestibule and entrance hallway floors, as these may become dangerous when wet. A minimum of wax should be used on the maintenance of floors to prevent surplus amounts being transferred to the soles of shoes. Nonslip waxes containing fine abrasive particles are recommended. Any temporary floor covering material should be of a kind that does not constitute a tripping hazard.

Carpet flooring should be compact with a dense surface of loop pile or felt type and should be attached to subsurfaces so as to allow wheelchairs to move freely without excessive friction, bunching or binding.

Parking Areas

Zoning or parking Bylaws should include requirements for parking for the physically handicapped.

Walkways

Although the minimum width for walks is 0.9 m, it is highly desirable that, where space allows, they be 1.5 m in width to allow wheelchair users to pass each other.

Elevators

Public buildings of more than 540 sq. m. of building area with more than 1 storey should have an elevator or other acceptable means of access from one floor to another for persons in wheelchairs.

Water Closet Stalls

Water closet stall doors should preferably swing outward against a side wall. In existing buildings, water closet stalls for persons with physical disabilities can be provided by combining 2 standard water closet stalls into 1 by removing the common partition and fitting a suitable door.



GLOSSARY

The purpose of this glossary is to introduce the reader to some basic concepts and terms commonly used when describing various disabilities.

It is important to note that a person with a physical handicap is not necessarily sick. Even progressive conditions can have long periods of stability and only a medical expert can properly assess the health of an individual.

The only generalization which can be made about physically disabled people is that they are all different!

For more information on specific conditions contact the Regional or Provincial Association concerned.

(See Appendix 3)

Amputations

The most frequent causes of amputations are diabetes, vascular disease or trauma. Amputations of the lower limbs usually occur at the hip, above or below the knee. Amputations of the arms usually occur at the shoulder, below or above the elbow or at the finger joints.

Arthritis

An inflammation of the joints and involvement of other systems. There are many kinds, three of the most common are:

1) Rheumatoid Arthritis (RA)

A chronic progressive systemic disease of unknown origin, manifested primarily by inflammation of the peripheral joints, especially the hands and feet. Drug and physical therapies are basic treatments. R.A. has a variable course sometimes affecting organs e.g. lungs, liver or kidneys.

2) Osteo-Arthritis

A degenerative joint disease marked by degeneration of the articular cartilage (between the joints), hypertrophy of the bone at the margins (enlargement of the ends of bone). Weight bearing joints such as hips, spine and knees are most commonly affected. A common cause of neck and back pain.

3) Gout

A hereditary form of arthritis marked by hyperuricemia (excess of Uric Acid in the blood) and by recurrent sudden arthritic attacks on a single joint.

Those with arthritis should be encouraged to continue normal activities.

Cerebral Palsy

A term used to describe the various muscular dysfunctions which result from injury to, or malformation of, areas of the brain which control motor functions of the body.

Cerebral palsy is not a disease, rather a group of disorders manifesting themselves in degrees of impairment ranging from mild to severe. Obvious manifestations of C.P. are stiff movements of the arms and legs, staggering gait, involuntary motion of the arms and legs, difficulty in speaking, chewing or swallowing and drooling. These conditions have been clinically classified under five generally recognized types.

Spasticity — Muscles tend to contract and become stiff or tense when put under stress which results in impairment of voluntary motion. One or more parts of the body may be involved.

Athetosis — Purposeless, irregular motions occur in the involved parts of the body. Coordination is difficult when voluntary movement is attempted.

Ataxia — A disturbance of the balance or postural sense. This causes a loss of equilibrium in walking or standing and difficulty in directing movements of the limbs or tongue. The disturbance occurs only when purposeful movement is attempted.

Tremor — Uncontrollable involuntary motions which occur in regular, rhythmic or alternating patterns. Tremor occurring on attempted movement is known as “intention tremor”.

Rigidity — The resistance of the muscles to slow passive motion through the entire range of a movement.

Many cerebral palsied people are very intelligent, but some have trouble speaking. It is important to remember that a speech impediment is not related to intellectual capacity.

Though the damage is irreparable, cerebral palsy does not get worse, coordination usually improves with therapy, training and activity.

Cystic Fibrosis

A hereditary pancreatic disorder of infancy and childhood affecting many organ systems, especially the mucus secreting glands of the respiratory and digestive systems.

In the past, few children lived beyond their third year. Now with drug and physical therapies more people with cystic fibrosis are able to live and work through adulthood with few limitations.

Diabetes Mellitus

A metabolic condition in which: the pancreas (a gland) is unable to produce enough insulin, or the body is unable to use the insulin produced. Without sufficient insulin the body cannot utilize the sugar (glucose) and starches present in the food consumed. This lack of pancreatic insulin can be compensated for by supplementing the body with prepared insulin.

Mild cases of diabetes can be controlled by dietary regulation alone.

Exercise is also important in controlling body weight and excess blood sugar.

Usually a prescribed combination of insulin, proper diet and exercise provides effective control of this condition. The controlled diabetic can be successfully employed in most occupations.

Regular Insulin

Reaches its peak of action about four hours after injection and maintains its effect for approximately eight hours after injection. Must be injected several times a day to maintain continuous action.

Globin Insulin

Becomes active in approximately two hours after injection and is effective for sixteen to twenty four hours.

Protamine Zinc Insulin

Becomes active in approximately six hours after injection and remains effective for over twenty four hours.

NPH Insulin

Becomes active in two hours after injection and remains effective for twenty four to thirty hours.

Disfigurement

Disfigurement may be due to hereditary factors or as a result of a disease or injury.

In a society which places such a high value on youth and stereotyped beauty, no people are subject to greater discrimination than those who do not fit the common pattern.

Epilepsy

Is not a disease, rather a symptom which can be produced by a variety of organic, or chemical disorders or injuries affecting the brain, which in turn cause erratic or uncontrolled electrical discharges within the nervous system.

Anyone can have a seizure if their nervous system is subjected to sufficient stimulus which generates an abnormal electrical discharge. For example, certain drugs or toxic substances can produce seizures in any individual.

Epileptics simply have an abnormally low neural threshold for certain stimuli.

There is no such thing as an “Epileptic Personality”. Each person must be viewed as an individual rather than being labelled as part of a general group. Epilepsy does not affect the individuals’ intellectual functioning. Most of those taking anti-convulsive drugs are seizure free and can live and work normally.

Grand Mal

Seizures in which the entire body is involved in a convulsion are called “grand mal” attacks. The person loses consciousness (with or without warnings), usually falling to the ground, sometimes with a cry or a groan. The muscles become tightened by spasms. After a short period the rigid state changes into a rhythmic jerking, causing a severe shaking of the limbs and head. The jerking gradually subsides, normal breathing resumes, normal colour returns to the face, and the person lies relaxed, in a sleep-like condition, breathing heavily. The person usually remains unconscious for a few minutes, sometimes longer. After recovering consciousness they will soon be able to continue their usual activities.

Petit Mal

Epileptic seizures in which the individual suddenly and briefly loses contact with their immediate surroundings without falling to the ground are called “petit mal” seizures. These seizures may take place many times each day and are of short duration. The person having this type of seizure will appear to stare vacantly and will look slightly dazed. To most people the individual seems to be staring or “day dreaming” for a few moments. These seizures are usually seen in children and tend to cease as the child reaches adult life.

Psychomotor Attack

Has the most complex pattern of behavior. These seizures may be characterized by: chewing and lip smacking, staring and confusion. In some patients, picking at clothes, or rubbing the hands or legs may occur. Although a psychomotor seizure may present a strange picture, the person experiencing the seizure is usually unaware of the situation.

Friedreich's Ataxia

A hereditary condition characterized by progressive ataxia (failure to control muscular action, unsteady gait and/or weakness in the limbs). The disorder first appears in the legs and progresses upwards.

Hearing Impairments

It is estimated that there are over 200,000 profoundly deaf people in Canada, and an additional 1,500,000 with hearing impairments.

Deafness may occur due to: hereditary factors, maternal diseases (rubella), the side effects of certain drugs, birth traumas, scarlet fever, meningitis, measles or severe ear infections.

Deafness is of two types:

- 1) Nerve deafness (sensorineural) is due to cochlear disease (disease of the spiral tube forming part of the inner ear) or interruption of the nerve fibres within the inner ear.
- 2) Conduction deafness is due to disease of the middle ear otosclerosis (formation of spongy bone in the capsule of the labyrinth of the ear) or chronic otitis media (inflammation of the middle ear), rupture of the ear drum. Conduction deafness can often be corrected by surgery.

For those who have a hearing impairment hearing aids can be beneficial but aids do not correct the condition, they simply amplify all sounds, therefore the person requires a period of adjustment before they can comfortably use one.

Early diagnosis of deafness in children is very important since many have been misdiagnosed as mentally retarded or emotionally disturbed. If a child is profoundly deaf the earlier they begin learning language the better chance they have of developing normally.

Heart Conditions

A general term covering a variety of specific heart ailments. Persons with heart conditions are able to function well on the job within their medically prescribed limitations. The more common conditions are classified as follows:

Hypertensive Heart Disease

More than twice as many people suffer from this type of heart impairment than any other. It results when prolonged high blood pressure causes enlargement of the heart, or narrowing or hardening of the arteries. If uncontrolled, hypertension can force the overworked heart into failure and cause progressive damage to the kidneys. It also greatly increases risk of heart attacks and strokes. Fortunately, hypertension can usually be controlled by drugs. The side effects of drug therapy are usually mild and treatment need not impede the person in the performance of their job.

Coronary Artery Disease

This is a condition whereby the heart muscle (myocardium) receives a less-than-normal amount of blood and oxygen, due to narrowing of the coronary arteries. Narrowing of these arteries usually results from buildup of fatty deposits in the walls of the blood vessels. Persons with this disease may have attacks of chest pain (angina pectoris). If a coronary artery becomes occluded (obstructed), a portion of the heart muscle dies, a condition known as myocardial infarction. Major factors increasing susceptibility to coronary heart disease are hypertension, diabetes, elevated blood levels of cholesterol and other fatty substances. Obesity increases susceptibility somewhat.

Rheumatic Heart Disease

This condition is the result of scarring of the heart valves caused by rheumatic fever. A great many rheumatic fever patients recover without permanent damage to the heart, but this disease may repeat itself and each attack renews the chances for heart damage. If damage to heart valves is slight, it may not handicap the individual. When handicaps do result, the damaged valve often can be repaired surgically or else replaced with an artificial valve or valve transplant. Many people can resume normal activities after such surgery.

Congenital Heart Disease

As the name implies, this impairment is one which is present at birth because of failure of the heart or major blood vessels near the heart to develop normally. The “blue baby” is an example of this type of heart disease. Inborn defects may be mild or serious. When they are mild, they may never cause any trouble; but when defects are serious, they interfere with circulation of the blood, slow the person’s growth, and reduce their energy. Recent dramatic progress in diagnosis, surgery, and medical care for congenital heart defects can restore many persons with this type of heart ailment to normal or near-normal health.

Congestive Heart Failure

A condition in which the heart fails to pump sufficient blood to meet the needs of the body causing fluid to accumulate in various tissues.

Bacterial Endocarditis

Infection of the inner lining of the heart chambers and the valves; and heart damage caused by diphtheria or a thyroid disorder.

Heart Block

Is a pathological condition in which the ventricular (lower cavity) beat of the heart does not follow the auricular (upper cavity) beat with normal regularity. This impairment sometimes is accompanied by Stokes-Adams syndrome, characterized by sudden attacks of unconsciousness, with or without convulsions. In persons with severe heart block, normal heart rate may be restored and maintained by electronic devices called pacemakers.

All the above types of heart disease may bring on congestive heart failure (cardiac insufficiency, heart dropsy), a condition in which the heart fails to pump sufficient blood to meet the needs of the body, and fluid accumulates in various tissues, interfering with their functions. The condition may be mild or severe and its common symptoms are swelling (edema) of the lower extremities and shortness of breath (dyspnea).

Mobility Limitations

Monoplegia

Paralysis of all the muscles of the limb.

Hemiplegia

Paralysis of one side of the body. The most common type of paralysis, often associated with cerebrovascular diseases (strokes).

Paraplegia

Paralysis of both legs, commonly associated with spinal cord disease or spinal cord injury.

Quadriplegia

Paralysis of all four limbs, commonly associated with spinal cord disease or spinal cord injury.

Paresis

Partial weakness in a certain area. Hence, paraparesis means weakness in the legs, quadraparesis means weakness in all four limbs, etc.

Most of those people with multiple paralyses use wheelchairs, crutches or braces for mobility. Though the condition is usually permanent these people can be healthy and very able to work in most jobs.

Multiple Sclerosis

One of the most common chronic progressive neurological diseases. Its cause is undetermined. It is characterized by demyelination (loss of the myelin which is the fatty sheath surrounding the axon of nerve fibres) in certain portions of the nervous system. Some classical features include impaired vision, nystagmus (involuntary movement of the eye ball), dysarthria (speech impairment), ataxia (failure to control muscular action often characterized by unsteady gait).

The average age of onset is 35, this condition may remit and recur for thirty years or more.

An interesting epidemiological fact indicates that this condition is rare between the equator and latitudes of thirty degrees north or south. It becomes more common with increasing latitudes. For example, M.S. is estimated to be six times more prevalent in Winnipeg as in New Orleans.

Many of those with M.S. are able to work successfully for many years.

Muscular Dystrophies

Genetically based conditions characterized by progressive weakness and wasting of the limbs and trunk (body). The major classifications are:

Childhood type of Duchenne's Pseudohypertrophic Pelvifemoral Muscular Dystrophy

The most frequent and severe form affecting children.

Facioscapulohumeral type of Landouzy-Dejerine

The average range of onset is between thirteen and twenty years. It affects functioning of the facial muscles and muscles of the pectoral girdle (shoulders). These people may not be able to raise their arms above their heads, but maintain normal strength in the hands and arms until an advanced age.

Limb-Girdle Dystrophy of Erb

Generally a slow progressive condition affecting the shoulders or pelvis and calves. Severe disability does not occur until the disease has been present for twenty years or more.

Distal Type

A slow progressive atrophy of the muscles of the hands and feet, beginning in middle life and producing only moderate disability.

Myotonic Dystrophy

Begins in early adult life characterized by myotonia (the inability to relax a muscle normally after its contraction).

Maintenance of normal activity is an important factor in management of muscular dystrophy.

Obesity

The most prevalent metabolic disorder occurring in countries where there is an abundant food supply.

It occurs when the caloric intake exceeds the energy requirements of the body.

As a result the body accumulates fat which is stored as adipose tissue.

In females the adipose tissue is distributed in the lower part of the trunk and extremities. In the male it is more often distributed in the upper part of the trunk, often sparing the extremities.

There are many reasons for obesity. Some of these include:

- Familial or cultural eating habits.
- Psychological factors: substitution of food for satisfaction ordinarily obtained from other sources.
- Hypothalamic relationships: lesions to the ventro medial nucleus of the hypothalamus (that part of the brain which is believed to control food intake).
- A hormonal deficiency of the anterior pituitary gland may cause weight gain.
- Hypothyroidism: obesity may be due to inadequate thyroid hormone.
- Diabetes Mellitus: obesity is both a common accompaniment of and a predisposing factor to diabetes mellitus.

Occupational Lung Diseases

Caused by exposure to job related environmental factors. Either restrictive or obstructive lung disease, or both, may occur depending upon the duration or intensity.

Three main classes of agents can cause occupational disease:

1. Gases, vapors and fumes
2. Mineral dusts
3. Organic dusts

Gaseous pollutants and fumes may cause illness by their own actions e.g., inflammation of the lining of the conducting airways, lung scarring, chemical pneumonia, pulmonary edema, or combining with hemoglobin. Some of the pollutants are ammonia, chlorine, phosgene, sulfur dioxide (pulp mill workers), nitrogen oxide (silo filler's disease), cadmium oxide, mercury vapor, and isocyanates (toluene 2-4 diisocyanate (TDI) and methylene-bisphenyl-isocyanate (MDI)) used in the manufacture and spraying of polyurethane. Increased levels of carboxyhemoglobin are found in those individuals who work in environments where the ambient levels of carbon monoxide are increased e.g., tunnel workers, firefighters, auto mechanics, etc. As the amount of carboxyhemoglobin increases, the oxygen-carrying capacity of the red blood cell is reduced and soon the other cells of the body become starved for oxygen.

Mineral dust exposure can result in a thickening of the walls of the air sacs (bronchitis), dust deposits may cause varied tissue response. This may follow exposure to aluminum, aluminum oxide, asbestos, asbestos substitutes (vermiculite — a silicate that occurs in flakes rather than fiber-form), beryllium (used in nuclear reactors and missile systems), coal dust and silicate. Coal dust can cause black lung (coal workers pneumoconiosis (CWP)). Silicosis is caused by breathing silica dust and is found in workers in the rock, granite and marble industries as well as metal miners, coal workers and those who make china and pottery. Mixed dust fibrosis, caused by quartz and other dusts inhaled simultaneously, is found most commonly in foundry workers, boiler scalers, and electric arc welders.

Organic dust exposure generally occurs on farms and in industries where food products containing vegetable or animal matter are processed into consumer goods. Some agents affect the conducting airways by acting as allergens, others act through direct toxic effects e.g. cotton dust (byssinosis). Organic dusts containing spores or molds can cause an inflammation of air sacs as in farmer's lung, bagasse (sugar cane), worker's lung, mushroom picker's lung, maple bark stripper's disease, sequiosis, cheese worker's lung, etc.

Lung Cancer

Has been attributed in part to the cancer producing effects of cigarette smoke, asbestos fibers, radon as found in uranium mining, 3-4 benzo (a) pyrene, iron ore (hematite), nickel as occurs in the early stages of nickel refining and bis (chlormethyl) ether.

Allergen

A substance which induces allergy (antigen).

Asbestosis

Occupational lung disorder resulting from exposure to asbestos fibers.

Atelectasis

Collapse or incomplete expansion of the lung.

Berylliosis

A disorder of the lungs and other parts of the body caused by inhalation or exposure to beryllium

Byssinosis

An occupational respiratory disease of cotton, flax and hemp workers.

Diffuse Interstitial Fibrosis

A diffuse scarring of the lung in which the lung volume is reduced.

Expectorants

Agents which reduce the thickness of mucus and thus facilitate removal by the cilia in the bronchial tree.

Fibrosis

The formation of tissues containing fibers (elongated threadlike structures).

Granulomatous Disorder

Coin-like lesions formed as a result of an inflammatory reaction to a physical, chemical or biological agent.

Kyphoscoliosis

Forward and lateral curvature of the spine resulting in decreased lung volumes and creating a bent or crouched posture.

Parenchymal Collapse

Collapse of the functioning structure of the lung e.g., air sac.

Pleural Effusion

A fluid formed in the space between the lungs and chest wall.

Pneumoconiosis

A scarring disorder of the lungs following prolonged exposure to mineral dusts. Three pathological features are dust deposit, scarring and emphysema.

Pneumothorax

An accumulation of air in the pleural space which may occur spontaneously or as the result of trauma or pressure changes.

Pulmonary Hyperinflation

Excessive trapping of air in the lungs. Inability to empty one's lungs adequately on expiration.

Second-Hand Smoke

The smoke to which non-smokers who remain in an environment where others are smoking are exposed. The deleterious effects are elevated blood carbon monoxide, exposure to increased concentrations of cadmium, tar, nicotine, 3-4 benzo(a)pyrene and ammonia.

Sequiosis

Exposure to moldy red wood dust resulting in an allergic pneumonia.

Tidal Volume

The volume of air inspired during normal respiration on a set period of time (about 500 ml).

Parkinson's Disease

A chronic degenerative condition affecting the nervous system during middle or late life. Rhythmic tremor of the limbs, a stooped posture, stiff slow movement, rigidity of muscles and fixity of facial expression are characteristic effects. Though the condition is chronic and progressive, most individuals with Parkinson's disease are able to work and live normally for many years after onset.

Respiratory Conditions

Chronic Obstructive Pulmonary Diseases (COPD)

The three most common forms of COPD are chronic bronchitis, asthma and emphysema.

Chronic Bronchitis

An inflammation of the lining of the conducting airways characterized by excessive mucus secretions and resulting in a cough productive of daily sputum for at least three months out of the year for two consecutive years. A person with a recurring cough productive of sputum most likely has chronic bronchitis if no other disease is present to account for the symptoms. Airway narrowing from inflammation may also be present in chronic bronchitis and can lead to a disabling shortness of breath.

Asthma

An episodic, reversible, increased responsiveness of the smooth muscle in the walls of the airways to various stimuli. This causes the airways to constrict which results in shortness of breath. There are a number of types of asthma.

- One type of asthma which affects children is associated with allergic susceptibility to pollen and grasses.
- A second type of asthma can be initiated by exercise, exposure to cold air or some types of drugs, cosmetics, etc.
- A third type of asthma is frequently associated with chest infections.

Emphysema

Involves the part of the lung beyond the terminal bronchioles. Unlike asthma and chronic bronchitis, it is characterized by an increase in the size (overdistention from loss of elasticity) and destruction of the walls of the air sacs (alveoli), resulting in a breakdown of the gas exchange capabilities. First for oxygen and later for carbon dioxide. As the condition progresses, a shortness of breath inappropriate for either the person's age or level of exertion occurs.

Restrictive Lung Diseases (RLD)

Results in decreased lung volumes and can be divided into two categories:

- 1) Extrapulmonary restriction which develops from causes outside the lung such as chest wall or spinal column deformity (kyphoscoliosis), respiratory muscle weakness (muscular dystrophy), diseases in the space between the lungs and the chest wall such as fluid in the chest (pleural effusion), scarring of the lining of the chest wall (fibrothorax), and obesity.
- 2) Restriction in the lungs which results from partial lung removal, tumors, heart disease with lung congestion, pneumonia, chronic infection (granulomatous disorders such as fungal infections, tuberculosis), generalized systemic diseases with lung as the target organ (sarcoidosis), diffuse scarring (Hamman-Rich Syndrome), and lung collapse (pneumothorax or atelectasis).

Visual Impairments

Astigmatism

Faulty vision which results from irregularity in the curvature of the refractive surfaces of the eye.

Blindness and Legal Blindness

This category includes those who have no sight as well as those who have severely reduced vision such as those:

- whose central visual acuity in the better eye is 20/200 or less with corrective lenses
- who have central vision better than 20/200 but have a visual field or peripheral vision which is reduced to 20° or less
- who have light perception only, or are able to only read large headlines
- who can see form or motion, or who have enough sight to get about unaided

- who are subject to day or night blindness. This is a condition of reduced dark adaptation resulting from a temporary vitamin A deficiency or permanently from retinitis pigmentosa or other peripheral retinal disease.

Though many blind people are unemployed, those who have found employment have excelled in a wide variety of professions and vocations.

Cataract

Partial or complete opacity of the crystalline lens or its capsule.

Colour Blindness

The result of imperfect functioning of the retina.

The most common type is red-green loss. The inability to distinguish between the two colours.

This condition affects males almost exclusively.

Conjunctivitis

Inflammation of the delicate membrane which lines the eyelids and covers the eyeball in front.

Cornea

The transparent front portion of the eyeball.

Diplopia

The seeing of single objects as two.

Glaucoma

A disease of the eye marked by above-normal intra-ocular pressure, resulting in hardness of the eye, atrophy of the retina, cupping of optic disk, and capable of producing blindness.

Gun-Barrel Vision

Shaft vision; tunnel vision; vision in which the field is narrow, as if the person were looking through a tube.

Hyperopia (Hypermetropia)

Farsightedness; a condition in which the focus of parallel rays of light is behind the retina due to an abnormally short front-to-back diameter of the eye or to subnormal refractive power of the transparent media.

Iris

The circular pigmented membrane behind the cornea, surrounding the pupil.

Keratitis

Inflammation of the cornea.

Monocular Vision

If one eye is blind, or if one eye refuses to register images in coordination with the better eye.

Myopia

Nearsightedness; usually due to an abnormally long front-to-back diameter of the eye, whereby the focal image is formed in front of the retina.

Nystagmus

An involuntary rapid movement of the eyeball, which may be horizontal, vertical, rotatory, or mixed.

O.D.

Oculus dexter, right eye.

O.S.

Oculus sinister, left eye.

O.U.

Oculus uterque; each eye.

O.U.

Oculi unitas, both eyes together.

Pinpoint Vision

Central vision; direct vision in the center of the eye only, with no visual field at all.

Presbyopia

Hyperopia; long sight and impairment of near vision due to advancing years.

Retina

The light-receptive layer and terminal expansion of the optic nerve in the eye. It is also referred to as the “nervous coat” forming the lining of the eyeball.

Retinitis

Inflammation of the retina marked by impairment of sight and distortion of vision.

Retinitis Pigmentosa

A disease, frequently hereditary, marked by: progressive pigmentation, deterioration of the retina, disturbance of its nerve elements and loss of vision.

Sclera

The firm, fibrous, outer membrane of the eyeball covering it entirely except the segment covered by the cornea.

Scleritis

Inflammation of the sclera. It may exist alone, or involve the cornea, iris, or choroid.

Strabismus

Deviation of the eye which the person cannot overcome.

Trachoma

An infectious disease of the conjunctiva and cornea, producing sensitivity to light, pain, discharge of tears, and ulceration.

Visual Acuity

Measured in terms of Snellen or Jaeger notations.

This tests the ability of the individual to read certain standard charts at standard distances.

A Snellen notation is used for indicating far vision.

A notation of 20/35 means that at a distance of 20 feet, the individual's eye reads on a Snellen chart what a normal eye could read at 35 feet. Hence the notation 20/20 for normal vision.

Jaeger text cards or Snellen near vision charts are used to test near vision. Jaeger cards are constructed on the same principle as Snellen charts but are numbered according to the typesize on them. A number 10 Jaeger card shows letters which the normal eye should see at 56 inches.

Visual Field

The total area perceived when the eyes are focused straight ahead. The visual field of each eye is plotted on a circular graph marked off in degrees along any radius, indicating 0° to 90° from the center to the periphery.

Vitreous Body

The semifluid, transparent substance which lies between the retina and the lens of the eye.

References:

Harrison's Principles of Internal Medicine
Seventh Edition 1974
McGraw Hill Book Company

Interviewing Guides for Specific Disabilities
U.S. Department of Labour.

*The Commission appreciates the
advice provided on the Glossary
by Dr. Renald Simard of the
Royal Ottawa Hospital.*

Appendix No. 1

Federal and Provincial Human Rights Commissions

Federal Human Rights Commissions

National Office:

Canadian Human Rights Commission
257 Slater Street
Ottawa, Ontario
K1A 1E1
Telephone: (613) 995-1151

Regional Offices:

Atlantic Region

Office address:
Lord Nelson Arcade
Lower Arcade
5675 Spring Garden Road
Halifax, Nova Scotia
B3J 1H1

Mailing address:
P.O. Box 3545
Halifax South Postal Station
Halifax, Nova Scotia
B3J 3J2
Telephone: (902) 426-8380

Région de Québec

2021 Avenue Union
Suite 1115, 11^e Etage
Montréal (Québec)
H3A 2S9
Telephone: (514) 283-5218

Prairie Region

Dayton Building
323 Portage Avenue
Room 211, 2nd Floor
Winnipeg, Manitoba
R3B 2C1
Telephone: (204) 949-2189

Ontario Region

Arthur Meighen Building
55 St. Clair Avenue East
Room 623, 6th Floor
Toronto, Ontario
M4T 1M2
Telephone: (416) 966-5527

Western Region

Montreal Trust Building
789 West Pender, Suite 1002
Vancouver, British Columbia
V6C 1H2
Telephone: (604) 666-2251

Provincial Human Rights Commissions

Newfoundland: Newfoundland Human Rights Commission
Department of Justice
P.O. Box 4750
St. John's, Nfld.
A1C 5T7
Telephone: (709) 737-2709

**Prince Edward
Island:** P.E.I. Human Rights Commission
180 Richmond Street
Province House Annex,
Room 4
P.O. Box 2000
Charlottetown, P.E.I.
C1A 7N8
Telephone: (902) 894-7797

Nova Scotia: N.S. Human Rights Commission
P.O. Box 2221
Halifax, N.S.
B3J 3C4
Telephone: (902) 424-4111

New Brunswick: N.B. Human Rights Commission
P.O. Box 6000
Fredericton, N.B.
E3B 5H1
Telephone: (506) 453-2301

Québec: Commission des droits de la personne du Québec
360, rue Saint-Jacques, Suite 611
Montréal, P.Q.
H2Y 1P5
Telephone: (514) 873-5146

Ontario: Ontario Human Rights Commission
400 University Avenue
Toronto, Ont.
M7A 1T7
Telephone: (416) 965-6841

Manitoba:

Manitoba Human Rights Commission
Suite 200 - 323 Portage Avenue
Winnipeg, Man.
R3B 2C1
Telephone: (204) 944-3007

Saskatchewan:

Saskatchewan Human Rights Commission
219A - 21st Street East
Saskatoon, Sask.
S7K 0B7
Telephone: (306) 664-5952

Alberta:

Alberta Human Rights Commission
501 Edwards Professional Building
10053 - 111th Street
Edmonton, Alta.
T5K 2H8
Telephone: (403) 427-7661

British Columbia B.C. Human Rights Commission
Ministry of Labour
Human Rights Branch
880 Douglas Street
Victoria, B.C.
V8W 2B7
Telephone: (604) 387-6861

Appendix No. 2

Canada Employment and Immigration Commission Regional Offices

Provincial Rehabilitation Offices

Provincial Workers' Compensation Boards

Canada Employment and Immigration Commission Regional Offices

Newfoundland: 167 Kenmouth Place
Box 12051
St. John's, Nfld.
A1B 3Z4
Telephone: (709) 737-5331

**Prince Edward
Island:** 199 Grafton Street
Box 8000
Charlottetown, P.E.I.
G1A 8K1
Telephone: (902) 892-0211

Nova Scotia: Royal Bank Building
Box 2463
Halifax, N.S.
B3J 3E4
Telephone: (902) 426-2988

New Brunswick: Priestman Centre
565 Priestman Street
Fredericton, N.B.
E3B 5V6
Telephone: (506) 452-3710

Québec:

1441, rue Saint-Urbain
9^e étage
Montréal (P.Q.)
H2X 2M8
Telephone: (514) 283-3964

135 Benoit - XV Boulevard
Quebec, P.Q.
G1L 2Y8
Telephone: (418) 694-3625

Ontario:

4900 Yonge Street
Willowdale, Ont.
M2N 6A8
Telephone: (416) 224-4500

Manitoba:

167 Lombard Avenue
Room 190
Grain Exchange Building
Winnipeg, Man.
R3B 0T6
Telephone: (204) 949-2231

Saskatchewan: 2101 Scarth Street
Room 800
Financial Building
Regina, Sask.
S4P 2H9
Telephone: (306) 569-6255

**Alberta & North
West Territories:** 9925 - 109th Avenue
5th floor
Edmonton, Alta.
T5K 2J8
Telephone: (403) 425-4582

**British Columbia
& Yukon:** Royal Centre
1055 W. Georgia Street
Box 11145
Vancouver, B.C.
V6E 2P8
Telephone: (604) 666-2282

Provincial Rehabilitation Offices

Newfoundland:

Provincial Co-ordinator of Rehabilitation
Department of Rehabilitation and Recreation
Confederation Building
St. John's, Nfld.
A1C 5T7
Telephone: (709) 737-3548

Prince Edward Island:

Director of Field Services
Department of Social Services
P.O. Box 2000
Charlottetown, P.E.I.
C1A 7N8
Telephone: (902) 892-5421

Nova Scotia:

Provincial Rehabilitation Co-ordinator
Department of Social Services
P.O. Box 696
Halifax, N.S.
B3J 2T7
Telephone: (902) 424-4390

New Brunswick: VRDP Co-ordinator
Department of Social Services
P.O. Box 6000
Fredericton, N.B.
E3B 5H1
Telephone: (506) 453-3633

Québec: Affaires Sociales/Social Affairs
Programme de réadaptation
40 - 1005 Chemin Ste-Foy
Québec, P.Q.
G1S 4N4
Telephone: (418) 643-4320

Ontario: Director, Rehabilitation Bureau
Ministry of Community and Social Services
Adult Services Branch
Parliament Buildings
4th Floor, Hepburn Block
Queen's Park
Toronto, Ont.
M7A 1E9
Telephone: (416) 965-2376

Manitoba:

Director and Provincial Co-ordinator
Rehabilitation Services
Department of Health and Social Development
139 Tuxedo Boulevard, Building 15
Winnipeg, Man.
R3N 0H6
Telephone: (204) 895-5134

Saskatchewan:

Director of Vocational Rehabilitation Division
Core Services Administration
Department of Social Services
Chateau Tower
1920 Broad Street
Regina, Sask.
S4P 3V6
Telephone: (306) 565-3844

Alberta:

Director, Vocational Rehabilitation Branch
Social Services & Community Health
Seventh Street Plaza
10030 - 107th Street
11th Floor
Edmonton, Alta.
T5J 3E4
Telephone: (403) 427-8830

British Columbia: Rehabilitation Co-ordinator
Aid to Handicapped
Department of Health
6th Floor - Broadway Centre
805 West Broadway
Vancouver, B.C.
V5Z 1K1
Telephone: (604) 873-4251

Yukon: Co-ordinator of Rehabilitation
Health Services Branch
Territorial Administration Building
P.O. Box 2703
Whitehorse, Yukon
Y1A 2C6
Telephone: (604) 667-5233

North West Territories: Director, Income Support
Department of Social Services
6th Floor, Precambrian Building
Yellowknife, N.W.T.
X1A 2L9
Telephone: (403) 873-7160

Provincial Workers' Compensation Boards

Newfoundland: Workers' Compensation Board
P.O. Box 9000
Station B
St John's, Newfoundland
A1A 3B8
Telephone: (709) 754-2940

**Prince Edward
Island:** Department of Labour
Workers' Compensation Board
60 Belvedere Avenue
Box 757
Charlottetown, P.E.I.
C1A 7L7
Telephone: (902) 894-8555

Nova Scotia: Department of Labour
Workmen's Compensation Board
5668 South Street
Halifax, Nova Scotia
B3J 1A6
Telephone: (902) 424-8663

New Brunswick: New Brunswick Workmen's Compensation Board
Corner of Portland and Hilyard Streets
P.O. Box 160
Saint John, New Brunswick
E2L 3X9
Telephone: (506) 652-2250

Québec: Travail et Main-d'oeuvre
Commission des accidents du travail
524, rue Bourdages
C.P. 1200
Québec, P.Q.
G1R 7E2
Telephone: (418) 643-5964

Ontario: Ministry of Labour
Workmen's Compensation Board
2 Bloor Street East
Toronto, Ontario
M4W 3C3
Telephone: (416) 965-8880

Manitoba:

The Workers' Compensation Board
333 Maryland Street
Winnipeg, Manitoba
R3G 1M2
Telephone: (204) 786-5471

Saskatchewan:

Workers' Compensation Board
1840 Lorne Street
Regina, Saskatchewan
S4P 2L8
Telephone: (306) 565-4370

Alberta:

Workers' Compensation Board
9912-107th Street
P.O. Box 2415
Edmonton, Alberta
T5J 2S5
Telephone: (403) 427-1100

Branch Offices:

132-16th Avenue North East
Calgary, Alberta
T2E 1J5
Telephone: (403) 276-3381

10022-102nd Avenue
Grande Prairie, Alberta
T8V 0Z7
Telephone: (403) 532-7751

1277-3rd Avenue South
Lethbridge, Alberta
T1J 0K3
Telephone: (403) 329-0877

204 Chinook Place
623 Fourth Street South East
Medicine Hat, Alberta
T1A 0L1
Telephone: (403) 529-3624

4808 Ross Street, Suite 401
Red Deer, Alberta
T4N 1X5
Telephone: (403) 347-2291

Rehabilitation Centre:

7123-119th Street
Edmonton, Alberta
T6G 1V7
Telephone: (403) 434-3441

**North West
Territories:**

Department of Public Services
Workers' Compensation Board
Yellowknife, N.W.T.
X1A 2L9
Telephone: (403) 873-7555

British Columbia:

Workers' Compensation Board
5255 Heather Street
Vancouver, British Columbia
V5Z 3L8
Telephone: (604) 266-0211

Yukon:

Workers' Compensation Advisory Board
P.O. Box 2703
Whitehorse, Yukon
Y1A 2C6
Telephone: (604) 667-5224

Appendix No. 3

Associations Concerned with Various Disabilities

Associations Concerned with Various Disabilities

The following is a list of head offices. Most of these organizations have local offices, which are also set up to provide information and service to the public.

Blind Organization of Ontario with self help Tactics

B.O.O.S.T.

Suite 408

100 Richmond Street East

Toronto, Ontario

M4X 1B2

Telephone: (416) 364-4639

Canadian Arthritis & Rheumatism Society

920 Yonge Street

Toronto, Ontario

M4W 3J7

Telephone: (416) 967-1414

Canadian Association of Friedreich's Ataxia

5620 C.A. Jobin Street

Montreal, Quebec

H1P 1H8

Telephone: (514) 321-8684

Canadian Cerebral Palsy Association

Suite 2110, 1 Yonge Street

Toronto, Ontario

M5E 1E8

Telephone: (416) 862-0340

Canadian Co-ordinating Council on Deafness

55 Parkdale Avenue

Ottawa, Ontario

K1Y 1E5

Telephone: (613) 728-0936

Canadian Cystic Fibrosis Foundation

161 Eglinton Avenue East

Suite 503

Toronto, Ontario

M4P 1J5

Telephone: (416) 485-9149

Canadian Diabetic Association

123 Edward Street, Suite 601

Toronto, Ontario

M5G 1E2

Telephone: (416) 593-4311

Canadian Heart Foundation

Suite 1200
1 Nicholas Street
Ottawa, Ontario
K1N 7B7
Telephone: (613) 237-4361

Canadian Hemophilia Society

Chedoke Centre
Patterson Building
P.O. Box 2085
Hamilton, Ontario
L8N 3R5
Telephone: (416) 387-2677

Canadian Lung Association

Suite 908
75 Albert Street
Ottawa, Ontario
K1P 5E7
Telephone: (613) 237-1208

The Canadian National Institute for the Blind

1929 Bayview Avenue
Toronto, Ontario
M4G 3E8
Telephone: (416) 486-2500

Canadian Paraplegic Association

520 Sutherland Drive
Toronto, Ontario
M4G 3V9
Telephone: (416) 422-5640

Canadian Red Cross Society

460 Jarvis Street
Toronto, Ontario
M4Y 2H5
Telephone: (416) 923-6692

Canadian Rehabilitation Council for the Disabled

Suite 2110
1 Yonge Street
Toronto, Ontario
M5E 1E8
(416) 862-0340

Coalition of Provincial Associations for the Handicapped

COPOH

B19-215 Garry Street

Winnipeg, Manitoba

R3C 3P3

Telephone: (204) 942-0673

Epilepsy Association

Suite 510-1260 Bay Street

Toronto, Ontario

M5R 2B1

Telephone: (416) 964-6077

Multiple Sclerosis Society of Canada

130 Bloor Street West

Suite 700

Toronto, Ontario

M5S 1N5

Telephone: (416) 924-4406

Muscular Dystrophy Association of Canada

74 Victoria Street

Suite 1014

Toronto, Ontario

M5C 2A5

Telephone: (416) 364-9079

Parkinson Foundation of Canada

Suite 232

55 Bloor Street, West

Toronto, Ontario

M5S 1M4

Telephone: (416) 964-1155



Notes

